

## Request for COVID-19 Vaccination Medical Accommodation

### Part 1 – To be completed by the employee

Name (print):

Claire Seme

Date:

Facility:

Autumn Care

Position:

CVA

Manager:

Work/Cell Phone:

704 883-9700

Date of Request:

I am requesting an accommodation from the Facility's COVID-19 vaccination policy because of a medical condition (including pregnancy or pregnancy related condition), disability or medical contraindication with the available vaccines. If my medical condition changes and I am able to have the vaccination in the future, I will notify the HR department.

I verify that the information I am submitting to substantiate my request for exemption from the Facility's COVID-19 vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that the Facility is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the Facility.

Employee Signature:

Date:

Claire Seme

Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the employee could safely receive?

This exemption should be:

☐ Temporary, expiring on: \_\_/\_\_/\_\_, or when

☒ Permanent

☐ Indefinite

Will allowing the employee to work in the workplace even though employee is not vaccinated pose a direct threat of harm to the employee or others in the workplace? (A direct threat is defined as a significant risk of substantial harm to the health or safety of the employee or others, which cannot be eliminated or reduced by a reasonable accommodation).

Are there any reasonable accommodations of which you are aware that would enable the unvaccinated employee to perform their job duties in the Facility's workplace without posing a direct threat to the health or safety of the employee or others? If so, please specify the reasonable accommodation and why you believe it will be effective.

**Part 2 – Medical Certification for Vaccination Accommodation - To be completed by a licensed practitioner which is acting within their respective scope of practice based on applicable state and local laws. The licensed practitioner cannot be yourself, a relative, Facility Medical Director or facility-based provider unless that person is the employee's established primary care physician.**

Dear Medical Provider,<sup>1</sup>

The above named Facility (in Part 1) requires vaccination against COVID-19 as a condition of employment in compliance with the Centers for Medicare & Medicaid Services Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule. The individual named above is seeking an exemption to this policy due to a medical condition (including pregnancy or pregnancy-related condition), disability, or medical contraindication. Please complete this form to assist the Facility in the reasonable accommodation process so that we can assess the employee's request and determine whether we can reasonably accommodate the employee without posing a significant risk of substantial harm to the health or safety of the employee or others, which cannot be eliminated or reduced by a reasonable accommodation. Please only provide information related to the condition(s) that support or are related to Employee's request for accommodation.

Should you have any questions or if you would like to review a job description, please contact the above named Facility at \_\_\_\_\_.

Reason condition makes COVID-19 vaccination contraindicated:

The patient and her husband had COVID in 2021. They both tested positive at that time. She did not require hospitalization. She has worked with and cared for COVID patients as well. I am certain with a reasonable degree that she has natural immunity. Furthermore, she reports having allergic type reactions when getting vaccinated in the past. Recommend she not get the vaccine.

<sup>1</sup> A Note to Health Care Providers Assisting Our Employees

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, you should not gather or provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I certify the above information to be true and accurate, and recommend that the above-named individual be exempted from the Facility's COVID-19 vaccination requirements.

Medical Provider Name (print):

Michael Kepley

Provider License #

27876

Provider NPI#:

1316939036

Practice Name & Address:

Davis Medical Group OBGYN

1446 Fern Creek Dr Stateville

Medical Provider Signature:

Michael A Kepley MD

Date:

704-978-2820

2/21/2022

**HR USE ONLY**

Date of Initial request: \_\_/\_\_/\_\_

Date certification received: \_\_/\_\_/\_\_

Accommodation request:

☐ Approved \_\_/\_\_/\_\_

Describe specific accommodation details:

\_\_\_\_\_  
\_\_\_\_\_

☐ Denied \_\_/\_\_/\_\_

Describe why accommodation is denied:

\_\_\_\_\_  
\_\_\_\_\_

Notification to employee: \_\_/\_\_/\_\_

Human Resource Representative: \_\_\_\_\_